Provider Specific

Dental

Q. Where do I get the correct code set for the dental HIPAA 837D 4010?

A. HIPAA compliant transactions will have to use codes that have been designated as national standards and listed in the HIPAA rule. The CDT-4 codes for Dental Services can be found at www.ada.org/prof/prac/manage/benefits/cdtguide.html.

Q. Where can I find this document Companion Guide for the 837 Dental Claim Version 4010 A1? Also, please clarify the use of the Implementation Guide and the Clarification Documents?

A. The Companion Guide document /Data Clarification for the 837 Dental Claim Version 4010A1 can be found at www.michigan.gov/mdch, click on Providers, click on HIPAA, HIPAA Implementation and then on Companion guide/ Data clarification. MDCH is using the Addenda version of the Implementation Guide (IG). The Dental Claims Companion guide is to be used with the IG, not as a substitute. These are companion documents that clarify content needed by MDCH. Blue Cross Blue Shield of Michigan (BCBSM) also has companion documents on their website to specify content needed for BCBSM claims.

Q. The Data Clarifications For The 837 Dental Claim Version 4010 suggests that the Loop 2400 SV304 Oral Cavity Designation Codes are listed in the HIPAA 837D 4010 Implementation Guide. However the Oral Cavity Designation Codes are also listed in the American Dental Association Codes Current Dental Terminology (ADA CDT) and they are different from the Oral Cavity Designation Codes listed in the HIPAA 837D 4010. What does this mean?

A. The HIPAA 837D 4010 does not list the ADA CDT as a source for Loop 2400 SV304 (Oral Cavity Designation). Therefore, the Oral Cavity Designation Codes listed in the HIPAA 837D 4010 Implementation Guide must be used when submitting HIPAA 837D 4010 claims.

Q. If submitting a claim for a patient with no other dental insurance, what are the loops that should be used (e.g. which loops contain Coordination of Benefits information)?

A. If a patient has no other insurances for dental submit information for all the required/relevant (e.g., Situationally Required) loops except the ones listed below.

- Loop 2320 (Other Subscriber Information)
- Loop 2330A (Other Subscriber Name)
- Loop 2330B (Other Payer Name)
- Loop 2330C (Other Payer Patient Information)
- Loop 2330D (Other Payer Referring Provider)
- Loop 2330E (Other Payer Rendering Provider)
- Loop 2430 (Line Adjudication Information)

Q. The current HIPAA 837D 4010 Implementation Guide (IG) (dated May 2000) does not have a place for submitting prior authorization for a dental procedure that requires one. What is the process to submit a prior authorization using the HIPAA 837D 4010?

A. A segment of the Prior Authorization is included in the HIPAA 837D 4010 Addenda (dated October 2001). Until the HIPAA 837D 4010 Addenda is approved by Department of Health and Human Services (HHS), the prior authorization can be sent in the Loop 2300 REF (Predetermination Identification) segment. This method is referenced in the Data Clarifications for the 837 Dental Claim, version 4010.
If submitting a claim for a patient with no other dental insurance, what are the loops that should be used (e.g. which loops contain Coordination of Benefits information)? If a patient has no other insurances for dental submit all information for all the loops except the ones listed below.

- Loop 2320 (Other Subscriber Information)
- Loop 2330A (Other Subscriber Name)
- Loop 2330B (Other Payer Name)
- Loop 2330C (Other Payer Patient Information)
- Loop 2330D (Other Payer Referring Provider)
- Loop 2330E (Other Payer Rendering Provider)
- Loop 2430 (Line Adjudication Information)

Q. What is the process to submit a dental claim for a procedure that has been performed multiple times on multiple teeth?

A. MDCH requires a separate service line for each dental service. Therefore, MDCH requires that each service for each tooth be listed separately. For example:

- Loop 2400 SV301-2 (Product/Service ID) will include the procedure code.
- Loop 2400 SV304 (Quantity) will include a quantity of 1.
- Loop 2400 TOO (Tooth Information) will only include one repeat for each dental service (e.g. Loop 2400 (Line Counter)).
- Loop 2400 TOO02 (Tooth Code) will include the tooth code/number pertaining to the dental service.
- Loop 2400 TOO03 (Tooth Surface Code) will include up to five tooth surfaces pertaining to the dental service.

Q. The Companion Document/Data Clarifications For The 837 Dental Claim Version 4010 suggests that the Loop 2400 SV304 Oral Cavity Designation Codes are listed in the HIPAA 837D 4010 Implementation Guide. However the Oral Cavity Designation Codes are also listed in the American Dental Association Codes Current Dental Terminology (ADA CDT) and they are different from the Oral Cavity Designation Codes listed in the HIPAA 837D 4010. What does this mean?

A. The HIPAA 837D 4010 and 4010A1 does not list the ADA CDT as a Code Source for Loop 2400 SV304 (Oral Cavity Designation). Therefore, the Oral Cavity Designation Codes listed in the HIPAA 837D 4010 and 4010A1 Implementation Guide must be used when submitting HIPAA 837D 4010 and 4010A1 claims.

Q. The Data Clarification Document suggests that MDCH will allow the submission of claims that are an original, a replacement, or a void/cancel. What is the utility of a replacement or void/cancel claim and how do I populate these claims?

A. Replacement claims are submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after DCH made payment. It is very important to include all correct service lines on the replacement claim, whether or not they were paid correctly. A replacement claim would include a "7" for claim replacement in Loop 2300 CLM05-3 (Claim Frequency Type Code) and the Original Claim Reference Number in Loop 2300 REF02 (Claim Original Reference Number). Also, see the Data Clarifications for the 837 Dental Claim, version 4010A1. A void/cancel claim is used to eliminate in its entirety a previously submitted claim for a specific Provider, Patient, Payer, Insured and 'Statement Covers Period'. A void/cancel claim must be the exact duplicate of a previously paid claim. A void/cancel claim would include an "8" for void/cancel in Loop 2300 CLM05-3 (Claim Frequency Type Code) and the Original Claim Reference Number in Loop 2300 REF02 (Claim Original Reference Number). When void/cancel claims are received, MDCH deletes the original claim and all money paid on the original claim will be taken back. See the Companion Guide for the 837 Dental Claim, version 4010A1, for both situations.

Q. What electronic format will MDCH accept for dental claims after October 16, 2003?

A. Dental providers must submit ANSI X12 837 Dental v 4010A1 for all claims submitted on or after October 1, 2003 (independent of date of service). Providers can continue to send the ADA paper format. However providers might risk delayed payment when submitting by paper. Please read the June 2003 Letter that is on the website: www.michigan.gov/mdch. Go to Providers, HIPAA and then HIPAA Implementation.

Q. The current HIPAA 837D 4010 Implementation Guide (IG) (dated May 2000) does not have a place for submitting prior authorization for a dental procedure that requires one. What is the process to submit a prior authorization using the HIPAA 837D 4010?

A. A segment for the Prior Authorization is included in the HIPAA 837D 4010A1 Addenda (dated October 2002). Please refer to MDCH's Companion guide for the Addenda version of Implementation guide for 837 dental claims to obtain guidance on submitting the prior authorization number.

Nursing Facilities

Q. Will a crosswalk be provided from the current proprietary electronic Nursing Facility claim format to the 837-I or EMCv5?

A. Several elements reported on the proprietary form cannot be captured on the new formats. MDCH policy changes under the Nursing Facility (NF) transition to national standard claim formats through the Uniform Billing Project have eliminated the use of some elements currently reported on the proprietary format, or transitioned the use

of those elements to an entirely different claim format. Providers should review the recently revised Chapter IV of the Michigan Medicaid Nursing Facility Manual, and the State Uniform Billing Manual to assess impact on provider-specific systems and modify individual claims data reporting systems accordingly. The authoritative crosswalk from the UB-92 (both paper and electronic) to the 837-I is found in Appendix F of the 837-Institutional Implementation Guide, version 4010.